Out-Patient Check-In Form

Time: _____ W or S

Please complete the information below and hold it until you are called. Registration personnel will call your name to be registered.

Patient Information:

Date: _____ Current Time: _____ Time of Appointment: _____

Social Security # (of patient): _____-_____-_____ Birthdate:____/____/____Hm Phone: (____)_____

Last Name: _____ First Name: _____ Middle Name: _____

Physical Address: _____ City: _____ Zip: _____

Mailing Address: _____ City: _____ Zip: _____

Is the patient a minor? Yes or No Marital Status: Married Single Widowed Divorced

Primary Insurance Carrier: _____ Policy Holder's Employer: _____

Policy Holder's Name: _____Policy Holder's Date of Birth: _____/____/_____

Outpatient Co-Pay: $ _____ Deductible: $ _____ Has your deductible been met? _____

Do you have a secondary insurance? _____ Doctor ordering Test/Procedure: _____

Is your visit due to an injury? Yes or No *Is the injury work related?* Yes or No

Employer: _____ *Claim #:* _____

I acknowledge that the above information is correct and current to the best of my knowledge.

_____ _____

Signature *Relationship*

For Office Use Only

Was Med Nec Required? _____ Was an ABN signed? _____

Comments/Notes:

_____

_____

_____

_____

_____

Registrar: _____